

## dr Chetty's Covid Treatment Part 7

49-62 minutes

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**Jean-Pierre Kiekens:** [00:00:08] Greetings to you all. My name is Jean-Pierre Kiekens from Covexit.com and I am pleased to announce Dr. Welcome Shankara Chetty from South Africa. welcome dr chetty

**dr Shankara Chetty:** [00:00:22] *Thanks for letting me be there Jean-Pierre. And good evening to all your listeners.*

**JP Kiekens:** [00:00:30] Dr. Chetty is a general practitioner. He has a lot of experience in the outpatient treatment of COVID 19. He has treated over 7000 patients so far. He holds degrees in Medicine and Surgery and also has postgraduate degrees in Genetics, Advanced Biology, Biochemistry and Microbiology. So [00:01:00] this is the third appearance of Dr. Chetty at Covexit.com. The [first appearance](#) , which continues to attract significant traffic to Covexit.com today, is about the 8-day therapy he developed, which focuses on the early inflammatory phase of COVID. At the second appearance of Dr. Chetty [00:01:30] ( [Part 2 of the series about Dr. Chetty's method on freizahn.de](#)) was about the treatment of the delta variant. Therefore, today we will focus on the Omicron variant. And my first question is the following. On November 11, four samples containing this variant were discovered. When did you hear about this omicron variant? What do you know [00:02:00] that we don't know about its origin?

**DrChetty:**[00:02:05] *Jean-Pierre, we first heard about this from Botswana and then some changes in the symptomatology were noticed in South Africa and we decided to sequence these cases and that way we found that they had the were similar to those found in Botswana. And so they shared that information with the world. But I don't think it's from South Africa or Botswana. Mutations occur spontaneously around the globe, so [00:02:30] I don't think we'll find out where it actually came from, but it was isolated very quickly in many other countries. So I think South Africa's sequencing skills came into play here. So just because we were the first to find the virus doesn't mean we're the ones who made the virus.*

**JPKiekens :** [00:02:58] Apparently the infected were [00:03:00] diplomats, have you heard which countries they came from?

**DrChetty :** [00:03:07] *No, the information doesn't seem to be available. But yes, Omicron is here, and I think the origin of the virus, this variant, is not that important. It is already spread all over the world. So where it comes from and where it spreads is really irrelevant. We need to look at each country and see how it is spreading in each country. Trying to assign blame to [00:03:30] is getting us nowhere.*

**JPKiekens :** [00:03:34] I wasn't trying to assign blame. Sorry, I was trying to figure out where the damn variant came from. It's going to have a big impact and we don't even know where it's coming from. That's kind of weird, isn't it? And most people think it's South Africa. I thought so just a few days ago.

**DrChetty :** [00:03:58] *Jean-Pierre, the variant [00:04:00] itself has many mutations and very unusual mutations. So, yes, there is some controversy as to where it originated. There is no lineage for these mutations. So we need to find out why they exist. It did not simply arise through a natural process of mutation, as it has no lineage or we have not found any 30 mutations in one variant is significant. (See my translation with Dr. Malone's remarks [on developmental leaps in Covid giants part 2](#) )*

**JPKiekens :** [00:04:27] Well the four people [00:04:30] who got these positive omicron tests were all vaccinated, fully vaccinated. This is the information we received. Does that mean anything to you?

**Dr Chetty :**[00:04:49] *Yes, in this new variant, the spike protein has changed significantly. This substantial change can [00:05:00] only be explained by selection favoring mutations in the virus that could circumvent the hurdles posed by vaccination, because the vaccines offer only very limited immunity to the spike protein . Thus, if a mutation occurs in a heavily vaccinated population, the mutations that cause the virus to evade vaccine protection are more likely to be found in*

the spike protein of the virus itself. So I think the omicron variant could be a variant [00:05:30] that was driven to mutate by exposure to a large population vaccinated with spike protein antibodies. (See also my blog article [The virus breeders](#) and various translations of interviews and articles by Dr. Vanden Bossche on [freizahn.de](#), such as [Continued mass vaccinations will only increase the evolutionary capacity of the SARS-CoV-2 spike protein even more than the Omicron version](#) )

**JP Kiekens** : [00:05:43] Based on your daily experience, and I think you've seen quite a number of patients today, can you find out who has omicron and who has delta?

**Dr Chetty** : [00:05:54] Jean-Pierre, the symptoms are very different. At Delta we see [00:06:00] the same heaviness of the initial presentation (as the original Wuhan version). We see the respiratory symptoms. We notice the deterioration on day 8, which can be severe. The two different variants can therefore be clinically distinguished from one another. With the omicron variant, we find that the patients do not have any breathing difficulties per se. You have a sore throat the first day that goes away completely by the second or third day [00:06:30]. But the main symptoms they show are fatigue and headaches. So these are the main symptoms that we have noticed with Omicron. So if I have a patient with no respiratory symptoms,

**JP Kiekens** : [00:06:52] But do patients come to you if they just have a headache and are tired?

**Dr Chetty** : [00:06:58] Yes they do. It's a headache, [00:07:00] tiredness. There is some body aches and pains. And remember, it starts with a temporary sore throat. I think there is enough panic and fear among the population that if they have a sore throat they want to see a doctor right away. So they know they have a flu-like illness. It's just that the symptoms typically don't involve the respiratory system.

**JP Kiekens** : [00:07:23] And what is the ratio of the two variants that you have seen?

**Dr Chetty** : [00:07:30] That's changed a lot in the last two or three weeks. It was all the Delta variant, which declined at the end of the third wave. When the fourth wave started, more delta cases started to appear again. But I would say 70 percent of the cases I see now look like the omicron variant.

**JP Kiekens** : [00:07:52] So what do you do with your patient when you diagnose the omicron variant?

**Dr Chetty** : [00:08:00] I generally congratulate them (laughs). No, the fact is that omicron is a mild variant. There's no need to panic. We treat it like a viral infection first, as I have done with all other variants of the different waves, and see if it resolves. We know that there can be an exacerbation on the eighth day triggered by a hypersensitivity reaction. With the omicron variant, we observed very slight hypersensitivity reactions in very few patients [00:08:30] on day 8. And I think that's why it's a milder variant. So it is hypersensitivity leading to hyperinflammation that is responsible for the mortality and morbidity of a particular variant, for the ability to cause an allergy or trigger this reaction. I think that with all the mutations in the spike protein, the spike protein has become less allergenic. So yes, with every patient we are still monitoring the eighth day. There are a select few who notice a mild reaction [00:09:00] which we are treating accordingly. But having said that, I have found in all the patients I have seen that the disease caused by omicron is fairly mild and relatively self-limiting, so symptomatic treatment is usually sufficient. who notice a slight reaction [00:09:00] which we treat accordingly. But having said that, I have found in all the patients I have seen that the disease caused by omicron is fairly mild and relatively self-limiting, so symptomatic treatment is usually sufficient.

**JP Kiekens** : [00:09:17] Can you summarize what you do at the first symptoms and what you do on day 8 if an intervention on day 8 [00:09:30] is warranted?

**Dr Chetty** : [00:09:34] OK. Jean-Pierre, what struck us is that there was a change on the eighth day. So I realized that we are dealing with a biphasic disease. The two phases are not linear and are not related to each other. So the severity of the first phase does not determine the severity of the second phase. So, the first phase is the viral disease. Their appearance changed with each variant. In the second [00:10:00] wave, gastrointestinal symptoms were added. Therefore, we treat the first phase of the disease as a self-limiting viral disease that is treated relatively symptomatically. Most, if not all, patients show signs of improvement by day 5 or 6 in most cases. For some it is much faster. It is therefore generally a symptomatic treatment. And of course we note the first day of the illness so that we can predict the eighth day and know when the second part of the illness might start. Our goal [ 00:10:30 ] is for the patients to have almost completely recovered from the

viral phase by day eight. So that's the first goal. On the eighth day, people who are allergic to the spike protein may experience a hypersensitivity reaction. Left untreated, this reaction leads to hyper-inflammation and hyper-clotting. that the patients have almost completely recovered from the viral phase by the eighth day. So that's the first goal. On the eighth day, people who are allergic to the spike protein may experience a hypersensitivity reaction. Left untreated, this reaction leads to hyper-inflammation and hyper-clotting. that the patients have almost completely recovered from the viral phase by the eighth day. So that's the first goal. On the eighth day, people who are allergic to the spike protein may experience a hypersensitivity reaction. Left untreated, this reaction leads to hyper-inflammation and hyper-clotting.

So predicting the eighth day, advising [00:11:00] the patients and educating them not to ignore any symptoms that day was crucial. When patients return on that eighth day, the treatment modality is suppression of a severe hypersensitivity reaction, which will require a variety of medications including antihistamines, montelukast, aspirin for coagulopathy, H2 blockers such as cimetidine for gastrointestinal symptoms, and a healthy dose of steroids [00: 11:30] to suppress the reaction in time. Every patient is slightly different. So from the eighth day, it requires a bit of management. So we use biomarkers to see if we're reversing, how severe the response is, and adjust treatment accordingly.

**JPKiekens** : [00:11:48] And what is your treatment protocol for the first few days of infection?

**DrChetty**: [00:11:56] In the first few days I tend to treat symptomatically. [00:12:00] So if a patient has body aches and fever, we give them something to quell that. In general, we use anti-inflammatory agents. My choice is either naproxen or celecoxib. I have tried colchicine but strangely I see many gastrointestinal side effects here with colchicine. So if you suffer from severe symptomatic body pain, you usually get an anti-inflammatory drug. We generally start with an antihistamine for those who have a runny nose and the like, so it's a very [00:12:30] symptomatic treatment. Those who have symptoms suggestive of higher viral load, look sick, severe pain, high fever and high temperature spikes usually give plasmoquine at a dose of 200 mg twice a day for five days as an antiviral, but this is used in few patients. Treatment with Plasmoquin is added to treatment only for those who do not appear to resolve by the seventh day. The remainder of the treatment [00:13:00] anticipates what might happen on day eight. So we add montelukast to try and stabilize the mast cells. Quercetin for some. We tend to use vitamin D3 and zinc to try and prevent an inappropriate immune response. So the whole area of treatment in the first phase is symptomatic and of course an attempt to prepare for what [00:13: 30] could happen on the eighth day. For those who have high viral loads, we just add plasmoquine to their treatment and that seems to stop viral replication.

**JPKiekens** : [00:13:40] And what about ivermectin, hydroxychloroquine?

**DrChetty** : [00:13:44] Hydroxychloroquine? Plasmoquin is a derivative of hydroxychloroquine. I've found it to work really well as an antiviral, but I've limited it to those who actually need it as the infection is self-limiting in the first phase. When it comes to ivermectin, I [00:14:00] have found greater benefit from ivermectin when used prophylactically, which is once weekly dosing, and I have found greater benefit from ivermectin after the eighth day. Ivermectin was originally developed to treat river blindness (filaria disease, [onchocerciasis](#)) used. River blindness causes something called eosinophilic pneumonia. The dead parasites trigger an allergic reaction in the lungs, and ivermectin has been shown to be quite effective at removing eosinophils from the lungs. [00:14:30] There are other drugs in this group, such as diethylcarbamazine- citrate, niclosamide or nitrousoxamide (??? 14:38), which are known to remove eosinophils from the lungs. Eosinophils in the lungs are usually due to an allergic reaction. My take on ivermectin was simple, that if a patient shows satiety problems or lung problems after 8 days, I will start ivermectin. However, ivermectin has now been superseded by [00:15:00] understanding of the pathology that occurs after day 8, and I've found the toolkit of medications I use to be far more useful to me, temporally and clinically brings as ivermectin.

**JPKiekens**: [00:15:16] So you know the official statistics in South Africa which show that the number of hospital admissions and the number of ICU admissions have not increased. Can you confirm that [00:15:30]? Is that what you see?

**DrChetty**: [00:15:34] Yes, Jean-Pierre, there have been very few, if any, hospital admissions with omicron and very few ICU admissions with omicron. Initially, hospitals were reported to be filling up with COVID patients, but then that was checked and we found that 80 percent of the omicron cases were in the hospital for other reasons. It was just an incidental finding as everyone admitted [00:16:00] needs to be tested for COVID. And so it was found that many of these patients tested positive for omicron but were asymptomatic. So they reported a high number of hospitalizations. But it wasn't because of omicron per se. A very small percentage were actually hospitalized for COVID-19.

**JPKiekens:** [00:16:21] So right now it is summer in South Africa and I guess there is a lot of sun and a lot of reasons why this virus [00:16:30] cannot multiply as much as it does in the winter months, especially in countries like Canada and Northern Europe. What do you think of the fear, the great fear, that there is in countries like Canada and the US of an omicron-induced hospital crisis?

**DrChetty:**[00:16:58] *Jean-Pierre, I think this is just scaremongering [00:17:00]. Another attempt to incite fear. At Omikron we are dealing with a mild variant that does not result in hospitalizations or deaths. So this variant could spread much faster than the Delta variant. The fear now is that it will spread so quickly and overwhelm the hospitals with admissions. But we haven't seen these instructions yet. So the [00:17:30] is another modeling tool to instill fear. There's no reason for us to plan for a surge in patient numbers that we can't handle, and if we have that kind of surge, how are we going to prevent it? And certainly not through vaccinations, which have proven to be ineffective against Omicron. So I think there is an unnecessary fear out there. Omicron is a far [00:18:00] more contagious variant and has the potential to spread very quickly, causing very mild disease and thereby crowding out the more virulent variants that cause more deaths in certain countries. So Omicron could be a godsend for countries with high mortality rates.*

**JPKiekens:** [00:18:24] So specifically, what do you recommend to the people, the individuals, [00:18:30] let's say, the ordinary citizens in Canada who are afraid? Of course, they can welcome it as good news if the variant is mild, but what is your advice to people in general, just go about your life or take every protective measure possible to prevent any form of the infectious disease? Also keep in mind that all these drugs, you know, the ivermectin [00:19:00] you mentioned, is totally unacceptable as a prophylactic in a country like Canada or even the US. It's very, very hard to get in most states, at least in the US. So what do you recommend people do?

**DrChetty:**[00:19:18] *Jean-Pierre, here in South Africa it has been recognized that public health measures have not worked. We found a large discrepancy between the cases tested and the seroprevalence of antibodies [00:19:30] in the population. This huge discrepancy suggests that public health responses have never been able to isolate all cases. And that's what the public health strategy was for. Detect, trace, isolate and thereby prevent the spread. Well, if you have an 80 percent seroprevalence in your community, your public health strategies clearly haven't worked. So South Africa has decided to give that up. We are no longer isolating patients. We no longer perform contact tracing. [00:20:00] I think we've given up isolating the virus from the rest of the community and trying to find it. Of course, a faulty PCR test didn't exactly make it easy. It was doomed.*

*Now for the advice I give my patients when it comes to dealing with this omicron variant. We are approaching the Christmas season (the interview was published on 12/22/21) and if there is to be a change in how we deal with it, then of course it has to be pragmatic. That's why I advise my patients to social distance. I advise them to [00:20:30] mingle with people who are in smaller groups. And I advise them that if they are having meetings and parties in their free time, they should try to do it outdoors where there is much less chance of spread. But there's nothing to be afraid of, you know. At the start of the pandemic - it's a respiratory virus that I knew about from the start that we can never contain it with public health measures - my patients laughed from the beginning. I told them: The [00:21:00] chance that you will contract the coronavirus through this pandemic is almost 100 percent. It's almost impossible to avoid, so it's probably best to choose your variants carefully, and that was a joke. So now we have a mild version. I think it's time to make a choice. You might not be so lucky with the next one. I think it's a mild variant. We shouldn't be afraid of it. And if we develop this disease, there's a good chance we'll survive it and develop good [00:21:30] immunity to it. my patients laughed from the start. I told them: The [00:21:00] chance that you will contract the coronavirus through this pandemic is almost 100 percent. It's almost impossible to avoid, so it's probably best to choose your variants carefully, and that was a joke. So now we have a mild version. I think it's time to make a choice. You might not be so lucky with the next one. I think it's a mild variant. We shouldn't be afraid of it. And if we develop this disease, there's a good chance we'll survive it and develop good [00:21:30] immunity to it. is almost 100 percent. It's almost impossible to avoid, so it's probably best to choose your variants carefully, and that was a joke. So now we have a mild version. I think it's time to make a choice. You might not be so lucky with the next one. I think it's a mild variant. We shouldn't be afraid of it. And if we develop this disease, there's a good chance we'll survive it and develop good [00:21:30] immunity to it. is almost 100 percent. It's*

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**JPKiekens:** [00:21:33] Someone I'm sure you know, Robert Malone, the inventor of mRNA vaccine technology, has claimed on US TV that Omicron could look like a Christmas present (see Dr. Malone's talk in [Covid giants part 2](#) ). Do you agree?

**DrChetty:** [00:21:53] See I was prompted by India Today two days after this variant was mentioned [00:22:00] to comment on what I think. And at the beginning of the pandemic, I was asked what I thought was a good vaccine. I said: "We should isolate the mildest strain of coronavirus using conventional methods and use it as a candidate for a live-attenuated vaccine. In this way we can vaccinate people. You will get an easy infection and develop strong immunity. And since it's a live vaccine, we wouldn't need to vaccinate entire populations [00:22:30] because it would spread by itself. When you got sick, you infected those around you with the same pathogen. This creates an artificial pandemic with a very mild strain, and herd immunity develops relatively quickly. Well, that's exactly what Omicron will do if we let it run its course instead of trying to corner it at every turn. We just have to make sure there is no mortality and morbidity and that seems to be taking care of itself [00:23:00]. So when I was doing this interview in India and they all closed their borders to South Africa, I found that very silly because we have a milder variant that is much more contagious and that is capable of crowding out far more virulent variants in the country. And of course we will negate the need for mass vaccination of your population for fear of the variant itself. So I think that dr. Malone is right that this is indeed a gift and we [00:23: 30] should be careful to close our borders to it and try to vaccinate ourselves from the situation. In fact, Reiner Füllmich (Dr. Chetty's, simultaneously translated into German interview of December 10th, 2021 with the Corona Committee is [indr Chetty's Covid treatment part 5](#) linked) asked the same question. There is a wave of Delta cases in Germany and as I am part of a group of doctors who are knowledgeable about early treatment, he wanted to know what I would suggest as a measure to solve the problem. My advice was to find 10 South Africans who just had the virus and then have them come to this country and celebrate. [00:24:00] They would spread Omicron in this country and displace Delta. That would be the best thing that could happen. (laughs) So I think, yeah, sometimes we have to let the science shine through.

**JPKiekens:** [00:24:09] But is there any solid evidence that omicron infection confers natural immunity after COVID infection?

**DrChetty:** [00:24:21] Look what the mutations of the virus itself are doing, whatever immunity Omicron confers will definitely be more comprehensive and [00:24:30] more effective than any of the current vaccines. So you have a choice. Do you get immunity from an ineffective vaccine? Or do you get your immunity from a mild variant of the natural virus. In any case, the immunity provided by the virus itself will be broader and far more robust than any vaccine could ever be. So let's compare apples to apples because Omicron grants [00:25:00] immunity, which will be relevant for future variants.

**JPKiekens:** [00:25:07] So you think that Omicron is a type of vaccine that surpasses all previous human-made vaccines.

**DrChetty:** [00:25:23] Absolutely, absolutely, because you have a natural viral infection. And [00:25:30] your repertoire of antibodies that you develop against this virus will therefore be extensive. It includes both the spike protein and the nucleocapsid and envelope proteins, which are not transferred by the vaccine. So it will definitely be a better immune stimulator than any vaccine could be. Because the vaccines only stimulate immunity against the wild-type spike protein, and that's a very narrow band of immunity. [00:26:00] In any case, I see many **more vaccinated patients becoming infected with omicron** . Now we cannot call people unvaccinated because unvaccinated people are not naive. They may have been through COVID infections and have some degree of immunity, so the term "unvaccinated" doesn't paint the whole picture. There are four groups we are dealing with now. We are dealing with people who have not been [00:26:30] vaccinated, who are naive about Corona and have never come into contact with it. There are people who have not been vaccinated but have had COVID infection in the past. There are people who have had COVID infection and have been vaccinated and this vaccine may have altered their immune status in a certain way. And then there are naive people who



have been vaccinated and are now being infected with Corona. So we are dealing here with four different groups of people who need to be examined separately,

**JPKiekens:** [00:27:14] I don't know if you're familiar with this, but in Denmark for example there is a huge increase in cases and there has been a report of alleged reinfections with omicron in people who had previously [00: 27:30] had recovered or at least had positive tests with either the Delta variant or the original strain of the Wuhan variant. What do you think of these reports of omicron reinfection? ( [Here is an article from January 8th](#) , 2021 on tkp.at)

**DrChetty:** [00:27:48] *With this variant, it's the first time I've seen unvaccinated people who have had COVID in the past being reinfected. So there's a slightly higher risk of [00:28:00] reinfection, and I think that's understandable given the mutations in this virus. But the unvaccinated people who reinfect themselves have a very mild infection because they are not naive. They have a wide repertoire of antibodies. I would call it an immune software update because the immunity wasn't robust enough to cover this variant. So the variant comes along and you update your immune system independently. It is therefore a mild, temporary illness. [00:28:30]However, full-blown disease usually develops in the vaccinated population because there are not enough antibodies to completely suppress the infection . And whether one (as a vaccinated person) develops a broad repertoire of antibodies has yet to be assessed .*

**JPKiekens:** [00:28:48] Also in Denmark there is an analysis carried out by an independent expert [00:29:00] who is not from Denmark, but based on the figures from Denmark a **negative effectiveness of the vaccine** suggests. At Omicron, the Imperial College London report suggests the same for people who have been double-vaccinated. Strangely [00:29:30] the booster shot seems to improve protection, but protection is really worst in the doubly vaccinated. Can you imagine what this variant's ability to thrive in vaccinated humans is all about?

**DrChetty:**[00:29:54] *Jean-Pierre, I think there are two or three different sides to this story when you look at [00:30:00] the immunity or the effect of the vaccine in the population itself. First, it is designed to induce the production of antibodies to the spike protein, and this is designed to confer a semblance of immunity, ie prevent infection and transmission. It is clear that the narrow range of antibodies does not offer this protection. So the CDC and FDA have taken an interest in it, and the manufacturer says it doesn't [00:30:30] protect against infection and transmission. Of course, if you have non-neutralizing antibodies, you're going to push mutations that evade those antibodies. So we would expect there to be more mutations in the spike protein. The second point, What we need to consider is the claim that vaccination reduces the severity of the disease and prevents death. This has nothing to do with the ability of these vaccines to stimulate the body to produce antibodies [00:31:00] because**these antibodies are non-neutralizing, non-sterilizing and have no effect at all on the disease itself. But I think the vaccine actually reduces the severity of the symptoms by instilling a degree of tolerance. But once your body stops making spike protein and you stop being exposed to it, tolerance begins to decline. And this is exactly what causes the effectiveness of the vaccines to decrease. [00:31:30] The antibodies didn't play any role in effectiveness from the start, they were a blank [00:31:37] from the start, a zero number.**So it's tolerance that seems to give you some measure of symptomatic relief. The third point we need to address is the side effects. Now we have **established conclusively that the vaccines do in fact cause immunosuppression. They damage your immune system.** This was noted in a very early study that claimed the vaccine's effectiveness. [00:32:00] So they represented the effectiveness of the vaccine versus baseline, and baseline was unvaccinated. So we had this increase in effectiveness from vaccination. And then after a month or two, we started to see her reverse and go back. So effectiveness continued to be measured, and we expected that effectiveness to come back to the**Baseline unvaccinated** would decrease. But **we were surprised to see that efficacy dropped below that baseline, meaning [00:32:30] immunity became worse than in unvaccinated people . So it showed damage to the immune system, an immunosuppression. And that's exactly what we're seeing all over the world.**That was the fear that unvaccinated people are less immunologically competent to deal with new variants. I think the studies show that the vaccines actually suppress the immune system's ability to deal with the virus or any new virus [00:33:00]. This appears to be global immunosuppression. I mean in a person who isn't in the whole world, even if everyone in the world seems to want to take this vaccine. But if it suppresses immunity globally and non-specifically, then **you will be susceptible to other viral infections and, of course, to reawakening of latent viruses that are present in your body. We saw that from the data that came out.***

**JPKiekens:** [00:33:29] What do you think [00:33:30] about the typical response in a number of countries to do booster vaccinations? Do you think this approach makes sense?

**DrChetty:** [00:33:43] *I think that's absolutely nonsensical. I wonder if the people making policy are even hearing what they just said themselves. I had this discussion here in South Africa with some of my colleagues to put things in simple context [00:34:00]. Omicron causes mild illness and does not lead to hospitalization or death. **The only thing vaccines have been shown to do is prevent serious illness and death.** Well, **Omicron doesn't cause serious illnesses or death. It causes mild illness.** So does your vaccine protect against minor illnesses? Because if it doesn't prevent minor illnesses, then it's of no use. **So don't see the point [00:34:30] of trying to vaccinate a population en masse to prevent serious illness and death from a variant that doesn't cause serious illness and death.** And of course, despite the fact that the vaccines have some serious side effects, the risk-benefit ratio has to be re-evaluated with each variant. The benefit of vaccination cannot outweigh the risk (perhaps worded a little vaguely in the original), and the risk of the virus does not justify taking such a risky step as a mass vaccination campaign. So it's [00:35:00] nonsensical. And of course we should compare the immunity conferred by Omicron to the immunity conferred by a booster dose, because **immunity from the booster dose is transient, unlike omicron infection where omicron confers long-lasting immunity.** So you could take a booster and avoid omicron infection. But the next variant, might not be so fortunate mild. So why [00:35:30] do you have to suppress something that actually poses no threat to you?*

**JPKiekens:** [00:35:36] So as for this booster to clear that up, even though most countries governments are pushing for new boosters to fight omicron, I understand well, think it's a bad idea ?

**DrChetty:**[00:35:55] I think Jean-Pierre it's a bad idea and that we have to [00:36:00] look at the context. Understanding the context of the boosters is crucial and we need to know the benefit/risk balance. Now we are dealing with a very mild variant. While the boosters offer some protection, remember that they are protection against a harmless variant. So the protection isn't really necessary, but that protection needs to be weighed against the risk of a booster shot. Now [00:36:30] we are well aware of the side effects of the vaccines. Do these side effects, or exposure to these side effects, justify the benefit if the benefit is accompanied by a very small risk reduction? because the risk in itself is very low? So I think it's extremely important to put this in context, **that the booster reduces a risk that is already almost non-existent and carries with it the risk of [00:37:00] side effects.** So we have to be very careful when trying to use boosters to prevent the variant from causing hospitalizations and deaths. The disease is too mild to try to prevent.

**JPKiekens:** [00:37:17] And this analysis that you're doing, would that also be applicable to, say, higher risk people in their 70's and 80's?

**DrChetty:** [00:37:29] *The [00:37:30] **high-risk population itself would not be at such a high risk if we offered early treatment. In South Africa, we at Omikron have seen that those considered to be high-risk groups still tend to get sick easily, so the hospitalizations and serious illnesses that we would have expected among these high-risk groups have not occurred.** So risk needs to be adequately quantified before we decide [00:38:00] on any mass strategy that involves risk. If vaccines pose no risk at all and are proven to be absolutely safe, then we can say: well, we have no risk from vaccination and the benefit it brings is worth it. But as long as we're dealing with a vaccine that carries risk, we have to balance that risk against the risk of hospitalization and [00:38:30] serious illness from omicron, which doesn't exist to date.*

**JPKiekens:** [00:38:38] The fact is that early treatments are suppressed and unavailable to the vast majority in a country like Canada, and in most European countries and in the US, even in most states, they know people don't even like it. If there is no early treatment, is your [00:39:00] analysis similar? Is it true that people shouldn't be afraid of Omicron even if they don't have access or don't know that there is early outpatient treatment?

**DrChetty:** [00:39:13] *Jean-Pierre, when we talk about early outpatient treatment, **understanding the pathogenesis of COVID and the way it causes the pathology is critical to the choice of treatment.** Well, yes, there are many drugs that have been shown to be useful but are very [00:39:30] controversial simply because we're trying to put them off-label, so to speak. Nonetheless, they are safe and effective. The controversy surrounding these drugs has led to many problems in accessing them. **However, if you look at the pathogenesis of COVID, we don't need unusual off-label drugs to actually treat this disease. We are dealing here with a simple allergic reaction on day 8, preceded by a self-limiting viral disease.** [00:40:00] So the **commercial drugs work**, and they're not banned in many countries. Many of the medications used to treat this are available over the counter. On the eighth day, if you have an allergic reaction, you need antihistamines, you need montelukast, you need a dose of steroids. These are readily available. What needs to be understood: **The world is now trying to treat a COVID pneumonia.** COVID pneumonia is infectious pneumonia caused*

by a viral infection. **But [00:40:30] what we are seeing is not COVID pneumonia. What we are seeing is hypersensitivity pneumonitis. This is a severe allergic reaction in the lungs themselves, so treatment varies widely.** Those still attempting to treat COVID pneumonia with antivirals still fail, while those who recognize that we are dealing with an inappropriate immune response on this eighth day succeed. The antihistamines, the steroids, and montelukast have all proven very useful. In my practice, I have found that the [00:41:00] quickest reversal of hypoxia is achieved through the use of antihistamines. I've had patients with 70 percent oxygen saturation levels improve to 85 percent within four hours when I gave a strong antihistamine. No other drug has demonstrated this remarkable benefit. So I think it's not about off-label use of drugs. It's about changing the label. The label reads: no more COVID pneumonia. [00:41:30] **It should be called hypersensitivity pneumonitis. and if it is hypersensitivity pneumonitis, all drugs used are properly approved for the purpose and can be made readily available to patients.** So I think that early treatment is crucial and accessible to patients when they know and understand what exactly is happening with this virus. We therefore do not try to use controversial and difficult-to-access treatments.

**JP Kiekens:** [00:42:02] So [00:42:00] all of what you're saying is anathema to governments who basically see hospitals as the only place to go, when you have a serious illness, when you develop a serious illness. Can you confirm to the skeptics that in the vast majority of cases, hospitalization [00:42:30] isn't even necessary when you have access to and receive treatment that early?

**Dr Chetty:** [00:42:41] Definitely. Jean-Pierre, in my work I am now approaching 8000 patients and these patients are patients that I have medically examined myself and many of them were presented to me seriously ill. It doesn't mean that the patients who come to us aren't as sick because we treat them as outpatients [00:43:00]. I've seen patients come to me with 40 percent saturation. They were brought in by an ambulance on a stretcher with oxygen on a drip. And with these patients, I continued home care with daily monitoring and a phone call to make sure medication was adjusted. And with all the 8000 patients I've had, there have been no deaths, no hospitalizations, and I haven't needed oxygen in my office [00:43:30]. Timely reversal of hypoxia eliminates the need for oxygen supplementation. You can't put a band-aid on an infected wound and claim it looks better. You have to address the problem. And when the problem is a hypersensitivity reaction in the lungs themselves, treating that problem shows remarkable timely improvement, so early outpatient treatment not only stops [00:44:00] all hospitalizations, but also the mortality and morbidity that we have seen can curb. **My experience can be shared by many doctors around the world. I have trained many doctors in Malaysia and Singapore and now also in Sri Lanka and in India and I have had feedback from some doctors who have applied this perspective to treatment.** Keep in mind that we are not talking about specific medications. We speak of a point of view (perspective). And so [00:44:30] a doctor who understands the perspective can choose what to use for treatment. No doctor treats a bee sting the same way. But the methodology, if properly understood, offers you a toolkit for treatment. And all these doctors that I spoke to have used this treatment method and got exactly the same results. No hospitalizations, no deaths, and no need for oxygen, even for critically ill patients. The claim that hospitals are the only place where this problem can be solved is, in my opinion, [00:45:00] a fallacy. It has sparked much controversy since the pandemic began. Just to put this in perspective, if you came to me with obesity and a very severe allergic reaction. Your face would be swollen, your throat would constrict. And I said, Jean-Pierre, there's no treatment for it. You will have to self-isolate at home. But if you feel like you can't make it, then you need to go to a hospital. After a few days of trying to manage the situation at home because a hospital is quite a daunting place, you realize you need to go to the hospital. [00:45:30] But by then you've already caused organ damage (by waiting). Your heart is damaged, your kidneys are damaged in that regard. And when you come to the hospital, you are now a seriously ill patient. And of course the doctor at the hospital has no idea that you were stung by a bee and that it was caused by an allergic reaction. So he does everything to save your life by working blindly. I think that's the reason for the failure at the hospital. **They kept chasing the bee without realizing that one is allergic to [00:46:00] its sting.** So I think early treatment is needed. Admission to hospital should be reserved for patients with severe comorbidities who may experience side effects or adverse effects from routinely used medications. I was forced to do intensive care on an outpatient basis [00:46:30] because I was afraid of going to the hospital. So if the intensive care treatment can be done at home and gives such remarkable results, I would like my colleagues to support me and provide me with a hospital bed every now and then with the same perspective and not change my treatment as soon as they mine get your hands on patients.

**JP Kiekens:** [00:46:52] To delve deeper into the topic from a political point of view, as you know, what you propose [00:47:00] stands in countries like the UK, Germany, France, Canada, the US and others not on the agenda at all. What do you say to the policy makers? What would you say, you know, to politicians, to the Prime Minister, what would you say to



the French President? What would you say to Boris Johnson? Angela Merkel? Joe Biden? Justin Trudeau? What advice would you give them to stop focusing [00:47:30] on hospitalization and instead focus on early treatment?

**DrChetty:**[00:47:37] *Jean-Pierre, I cannot understand why early treatment was not used from the start. When you deal with an illness, you treat the sick patient first. When a patient is not feeling well, as a doctor you do everything you can to treat the patient. You don't abandon the patient and say, well, if you get worse, you go [00:48:00] to the hospital. Intervention is usually a public health strategy, followed by treatment of those who have the disease, and only when that treatment fails to stem the spread and mortality and morbidity of the disease do they stop and look for vaccination. Vaccination is not a primary policy, so it was really silly to using them as a primary strategy in this pandemic. [00:48:30] If I were dealing with politicians who just don't know the science, it would be easy for me to whip up the logic and get them to understand what is required. but unfortunately, it seems that ignorance has an agenda , and that makes it harder to change. Every time you show science, science is pushed off the agenda.* And I don't think it's my job to turn [00:49:00] donkeys into horses. You have to start seeing the light all by yourself. If they fail to see the benefit of early treatment, given what has happened in the world so far, then there is definitely an agenda that ignorance dictates. If you look at Dr. (Fernando) Valerio in Honduras, like me, he started treatment very early in the pandemic. He's a critical care physician who took the opportunity to examine patients, understand [00:49:30] treatments and observe the speed of recovery. And then he managed to get the Honduran government to say we need early treatment.

*They gave up on ventilation very early on because it wasn't producing the desired results. And I think it's easy to understand that you can't do the same thing over and over again to get a different result. So if something wasn't working, they were willing to change it. And now there are zero COVID deaths in Honduras. They've managed to completely contain the pandemic and that's simply [00:50:00] due to a mix of factors. Early Treatment Yes, their country had a vaccination policy, but I think the most important thing is that they limited their vaccinations to the high-risk groups, while the rest of the population actually got treated early and survived. Now vaccination is not a means of escaping the pandemic itself. Very easily: If we treated every person and every person survived COVID, we would achieve [00:50:30] herd immunity. And then the patients who are not at risk and can be treated easily will form the basis for herd immunity. So why are we locking them up and trying to vaccinate them? We should give those who are not at risk the opportunity to come into contact with COVID and form the basis for herd immunity. This is what will protect our senior citizens. That's what will protect the vulnerable , because the non-vulnerable are the [00:51:00] majority in the herd immunity pool, and isolating people, locking people up, vaccinating people isn't going to get us there . Those who are vulnerable will still be exposed to the virus and herd immunity is never achieved by those who are not vulnerable.*

**JPKiekens:** [00:51:18] And coming back to the subject of the interview, Omicron is a step towards herd immunity.

**DrChetty:**[00:51:27] *Yes, definitely. Omicron, you see, [00:51:30] I'm cautiously optimistic or cautiously optimistic. With Omicron, the mutations that have occurred are a bit worrying in that they occurred so suddenly and so many of them in one go. And of course we are aware that we are not dealing with a natural virus here. This could be a new, constructed variant. So it could be a mild infection [00:52:00] with a spike in the tail. Therefore, we need to monitor patients over a longer period of time to ensure full recovery. We don't want to see side effects of the omicron infection after two or three months that we didn't anticipate. So I'm optimistic that Omicron will give us much needed herd immunity, but I'm wary of the thorn in the tail. I also have concerns that the vaccinated population receiving Omicron [00:52:30] will not be able to develop broad, robust immunity to it. And that would be the population that would produce future variants and future infections, and those infections could elude the natural immunity that infection confers on unvaccinated people. And so, yes, cautiously optimistic with Omikron, .... And that would be the population that would produce future variants and future infections, and those infections could elude the natural immunity that infection confers on unvaccinated people. And so, yes, cautiously optimistic with Omikron, .... And that would be the population that would produce future variants and future infections, and those infections could elude the natural immunity that infection confers on unvaccinated people. And so, yes, cautiously optimistic with Omikron, ....*

**JPKiekens:** [00:52:55] In your opinion, is there any impact on the future [00:53:00] development of this pandemic?

**DrChetty:**[00:53:05] *With the current variant and the mutations that we are seeing, we need to understand how this change in spike protein will affect the body. After all, the spike protein is the primary causative agent of COVID disease, not the virus itself. So the virus is a temporary illness. It is a pathogen, but it causes a temporary pathology. He is not the main causative agent of COVID disease. The pathology [00:53:30] that causes all of the mortality and morbidity in COVID*

disease is triggered by the spike protein. So, the main causative agent of COVID disease is the spike protein. And now that the primary pathogen has changed through this mutation, we need to understand how the pathology changes, and that change in pathology will tell us, once we understand them, allow to understand all the long-term implications of this new variant. So I think we have to be careful in that regard. However, as for the long-term pandemic [00:54:00] itself, I believe that if Omicron turns out to be the variant that will bring us this herd immunity, that well heralds the end of the pandemic. Pandemics tend to naturally evolve into milder variants that are more contagious, and that's what we saw with Omicron: a milder variant that's much more contagious. This makes the virus endemic, meaning it becomes fully endemic. We're only going to be scared [00:54:30] if we continue to test every person who has a mild sniffle. I think that's it what the natural infection and development of a pandemic usually does. So to look at Omicron we could report 20000 cases today. But what we don't hear is that only a thousand of them are mildly ill. So the numbers don't show the level of fear that should prevail in society, or the level of concern that should prevail. So I think we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms, where hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly? So to look at Omicron we could report 20000 cases today. But what we don't hear is that only a thousand of them are mildly ill. So the numbers don't show the level of fear that should prevail in society, or the level of concern that should prevail. So I think we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms, where hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly? So to look at Omicron we could report 20000 cases today. But what we don't hear is that only a thousand of them are mildly ill. So the numbers don't show the level of fear that should prevail in society, or the level of concern that should prevail. So I think we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms, where hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly? that only a thousand of them are mildly ill. So the numbers don't show the level of fear that should prevail in society, or the level of concern that should prevail. So I think we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms, where hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly? that only a thousand of them are mildly ill. So the numbers don't show the level of fear that should prevail in society, or the level of concern that should prevail. So I think we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms, where hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly? that we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms who can have a hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly? that we need to stop reporting [00:55:00] cases, stop testing asymptomatic people, stop testing contacts, only test people with symptoms and only test people with severe symptoms who can have a hospitalization might be considered. The others have a temporary illness and will get through it. So why should one know that they were doing badly?

**JPKiekens:** [00:55:23] Is there anything else you would like to add before we close?

**DrChetty:** [00:55:27] ***I think Omicron is a godsend. We [00:55:30] have to be careful. But again, we are dealing with a natural evolution that we should not ignore. We have spent two years neglecting natural immunity and it has worked to our detriment. All with the aim of vaccinating everyone. So we have ignored natural immunity. We shouldn't make the same mistake about Omicron. Let's not [00:56:00] try to put the hand of man above what nature is trying to do. This could lead to our downfall in the future.***

**JPKiekens:** [00:56:14] I have to thank you so much.

**DrChetty:** [00:56:16] Thank you very much. Thank you Jean-Piere for letting me be there.

end of translation

